Clark County
Regional Support Network

Special Needs Request

CONSUMER NAME: _____ DATE: _____/_____/_____

DATE OF BIRTH: _____ PARENT/GUARDIAN NAME: _____
(if under 18)

CONSUMER SS #: _____-_____-_____ CONSUMER PHONE: (_____)_____-_____

CHECK TO: _____ ❑ MAIL ❑ PICK UP
(Check to be issued directly to service provider)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____)_____-_____

REQUESTING AGENCY/PERSON: _____

PHONE: (_____)_____-_____ FAX: (_____)_____-_____

TOTAL AMOUNT NEEDED: $_____

BRIEFLY DESCRIBE NEED FOR REQUEST: *Address consumer's financial resources and ability to contribute.*

_____

_____

_____

_____

IS THERE A FUNCTIONING ITC/WRAP-AROUND TEAM? ❑ YES ❑ NO

IF SO, IS THE TEAM IN AGREEMENT WITH THE REQUEST? ❑ YES ❑ NO

HOW DOES THIS REQUEST SUPPORT THE INDIVIDUALIZED AND TAILORED CARE PLAN?
(Please attach ITC Plan & Budget Form, if applicable.)

_____

_____

_____

_____

OTHER FUNDING SOURCES EXPLORED	AMOUNT PROVIDED
1.	1.
2.	2.
3.	3.

CONSUMER NAME: _____ DATE: _____/_____/_____

REVIEW COMMITTEE SIGNATURES:

1. _____ ❑ APPROVE ❑ DENY

REASON FOR DENIAL: _____

2. _____ ❑ APPROVE ❑ DENY

REASON FOR DENIAL: _____

3. _____ ❑ APPROVE ❑ DENY

REASON FOR DENIAL: _____

DATE REQUEST RECEIVED BY RSN: _____/_____/_____

REQUEST REPONSE MADE TO: _____ DATE: _____/_____/_____

BY (RSN CARE MANAGER): _____